

ATTACHMENT 6

Sample CMS 1500 claim form for case management services

HEALTH INSURANCE CLAIM FORM										PICA																																																																																																																																																																																																																																							
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890																																																																																																																																																																																																																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																																																																									
5. PATIENT'S ADDRESS (No., Street) 609 Willow St					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)																																																																																																																																																																																																																																									
CITY Anytown			STATE WI		CITY			STATE																																																																																																																																																																																																																																									
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX			ZIP CODE		TELEPHONE (INCLUDE AREA CODE)																																																																																																																																																																																																																																										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																																																																																																																									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																																																																																																																																									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					c. OTHER INSURED'S NAME OR SCHOOL NAME			c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																																																																																																																									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																																																																																																																																																																																									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																																																																																																																																																																							
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																																																																																																																																																																																																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V15.9										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																																																																																							
2. _____ 3. _____ 4. _____										23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																																																																							
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">A DATE(S) OF SERVICE From To</th> <th colspan="2">B Place of Service</th> <th colspan="2">C Type of Service</th> <th colspan="2">D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="2">E DIAGNOSIS CODE</th> <th colspan="2">F \$ CHARGES</th> <th colspan="2">G DAYS OR UNITS</th> <th colspan="2">H EPSTD Family Plan</th> <th colspan="2">I EMG</th> <th colspan="2">J COB</th> <th colspan="2">K RESERVED FOR LOCAL USE</th> </tr> <tr> <th>MM</th><th>DD</th><th>YY</th> <th>MM</th><th>YY</th> <th></th><th></th> <th></th><th></th> <th></th><th></th> <th></th><th></th> <th></th><th></th> <th></th><th></th> <th></th><th></th> <th></th><th></th> <th></th><th></th> </tr> </thead> <tbody> <tr> <td>10</td><td>21</td><td>03</td> <td></td><td></td> <td>71</td><td></td> <td>T1017</td><td>U1 U5</td> <td>1</td> <td></td> <td>XX</td><td>XX</td> <td>5.0</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>10</td><td>29</td><td>03</td> <td></td><td></td> <td>12</td><td></td> <td>T1017</td><td>U2 U5</td> <td>1</td> <td></td> <td>XX</td><td>XX</td> <td>5.3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>11</td><td>25</td><td>03</td> <td></td><td></td> <td>12</td><td></td> <td>T1017</td><td>U3 U5</td> <td>1</td> <td></td> <td>XX</td><td>XX</td> <td>8.7</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>												A DATE(S) OF SERVICE From To			B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSTD Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE		MM	DD	YY	MM	YY																			10	21	03			71		T1017	U1 U5	1		XX	XX	5.0										10	29	03			12		T1017	U2 U5	1		XX	XX	5.3										11	25	03			12		T1017	U3 U5	1		XX	XX	8.7																																																																																																																												
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25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 1234JED			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XX XX		29. AMOUNT PAID \$		30. BALANCE DUE \$ XX XX																																																																																																																																																																																																																																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) J.M. Williams MM/DD/YY					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 87654321																																																																																																																																																																																																																																									
SIGNED _____ DATE _____					PIN# _____ GRP# _____			PIN# _____ GRP# _____																																																																																																																																																																																																																																									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)